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Evidence for accountability

Using evidence in the audit, inspection and scrutiny
of UK government

A close-up photograph of several interlocking brass gears, showing their teeth and the mechanical structure. The gears are made of a polished metal, likely brass, and are set against a blurred background.

Dr Ruth Levitt, Professor Steve Martin,
Professor Sandra Nutley and William Solesbury



Nuffield Foundation
28 Bedford Square
London WC1B 3JS

Telephone 020 7631 0566
www.nuffieldfoundation.org

The Nuffield Foundation is an endowed charitable trust that aims to improve social well-being in the widest sense. We fund research and innovation in education and social policy. We also work to build capacity in education and science and social science research.

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Introduction

The UK Government is held to account not only by the electorate, but also by a range of organisations charged with the audit, inspection and scrutiny of its executive branches.

The role of these agencies is the subject of much debate, but critics and defenders alike are often poorly informed about how these agencies actually operate. For example:

- How do they collect evidence, and how is this evidence used to make judgements about the performance of public services?
- What difference does their work make to the organisations they scrutinise?

This knowledge is essential to making a sound assessment of the effectiveness of audit, inspection and scrutiny agencies.

This briefing paper presents findings from research designed to answer these questions. Based on these we have identified eight principles for the effective use of evidence in audit, inspection and scrutiny.

These principles are designed to assist audit, inspection and scrutiny practitioners. They should also be a useful guide for policy makers seeking to refine or reshape the accountability landscape.

I. The role of audit, inspection and scrutiny

In theory, elections are the main method by which UK citizens hold executive government to account. In addition to this democratic accountability, however, there exists a professional accountability function comprised of audit, inspection and scrutiny mechanisms. This function has expanded over recent decades and it has been argued that “the wider system of checks and balances and ways by which public services are held to account and helped to improve, taken together, can be regarded as almost amounting to a ‘fourth arm of governance’”¹ alongside legislature, executive and judiciary.

There are several reasons for this expansion. As citizens have become better educated and informed, and consequently better able to demand a greater say in deciding who will govern them and how they wish to be governed, they have sought more information – greater transparency – about the functioning of the executive branch. These examinations meant that scrutiny or audit or investigation of the executive could no longer remain the province of a small cadre of tax inspectors or of occasional committees of inquiry.

As a result, we have seen greater professionalisation, and proliferation, of the accountability function.

More recently, governments have given the following reasons for increased audit, inspection and scrutiny activity:

- The need to use “long distance mechanics of control” to manage increasingly dispersed (and contracted out) forms of service provision.
- The need to guard against risk (such as high profile service failures).
- The need to drive improvement (in return for real terms increases in spending over the last decade, especially in healthcare and education).

So the reach and remit of audit, inspection and scrutiny agencies, as defined in **Table I**, have grown over the past two decades.

¹ Clive Grace, *The rapidly changing world of audit and inspection*, PMPA Review, November 2004, p6.

TABLE 1: AUDIT, INSPECTION AND SCRUTINY *

Audit	Periodic external assessment of corporate governance and management systems, financial statements and underlying financial systems, and the performance, performance management and reporting of public bodies.
Inspection	Periodic, targeted assessment of specific services, to check whether they are meeting national and local performance standards, legislative and professional requirements, and the needs of service users.
Scrutiny	Public inquiry into aspects of (national or local) government policy and performance, initiated and undertaken by a group of elected members.

* working definitions used in this paper; adapted from statements by the Scottish Executive and the Centre for Public Scrutiny

Reach and remit

Increasing numbers of sectors, services and government bodies are subject to audit, inspection and scrutiny. Childcare and foundation hospitals are now assessed, and while education and social services have been subject to external inspection for some time, in the last decade this has expanded to include most other local authority services.

Devolution of governmental powers has also increased the number of audit, inspection and scrutiny organisations operating in the UK as a whole, with additional agencies operating exclusively in Scotland and Wales.²

Approaches

Significant changes are also evident in the **approaches** taken by audit, inspection and scrutiny bodies. National audit offices, public services inspectorates and scrutiny bodies have adopted new systems for assessing risk, planning investigations proportionate to desired gains, gathering information and making judgements. In addition, whereas in the past systems of audit or inspection were mainly designed to establish how well or badly a particular body or service was performing against certain standards, current systems are increasingly designed not only to assess, but also to increase the capacity for improvement.³

² including for example the Accounts Commission (Scotland) and Wales Audit Office.

³ See for example Welsh Assembly Government, *Inspection, Audit and Regulation in Wales*, Policy Statement, 2009, section 3; Audit Commission strategic objective no. 3 'to encourage continual improvement in public service so they meet the changing needs of diverse communities and provide fair access for all'.

These developments have attracted some criticisms; for example the accountability landscape is often characterised as over-crowded and not well integrated:

“... many of the current external scrutiny arrangements are a result of assurance being required about particular public services at a particular point in time, and these arrangements have not subsequently been subjected to a rigorous assessment as to whether they are still required. Further, where new external scrutiny has been introduced, there has been no real prioritisation against existing requirements and how new scrutiny should fit in an already cluttered landscape.”⁴

Indeed, there are concerns that the proliferation of accountability mechanisms is not only costly but may be counter-productive:

“The proliferating forms of accountability that have been a feature of public and professional life in the UK for some years do not appear to have worked. The audit is a good example – originally a specific financial function, we now have clinical, ethical and green audits, audits in education – and the list goes on. On one view, we need to introduce more and more exacting forms of accountability that are less readily evaded or flouted. Relying on trust seems too risky. Formal systems of accountability might encourage people to live up to their obligations, so forms of accountability seem indispensable. But do they replace trust or improve the basis for placing it?”⁵

And there are searching questions about what these developments mean for the balance between checking and trusting in our society:

“... For a long time local councils have been under increasing pressure from a growing number of inspections which not only duplicates unnecessary work, but are costly and can hinder the delivery of better local services rather than do what they are meant to – help improve them.”⁶

In response, governments have repeatedly promised to reduce the burden of such oversight. There have been mergers of inspectorates, for example:

- By April 2011 there will be three main public service inspection bodies in Scotland: Health Improvement Scotland, HMIE, Social Care and Social Work Improvement Scotland.

4 Lorne Crerar, *The Crerar Review: The report of the independent review of regulation, audit, inspection and complaints handling of public services in Scotland*, September 2007, foreword.

5 Onora O'Neill, *Holding accountability to account*, Beveridge Lecture, October 2009.

6 Cllr Simon Milton, *Inspection burden more important than inspectorate numbers*, Local Government Association press statement, 16 March 2005.

- In England, Ofsted now has responsibility for standards in schools, adult learning, and social care services for children.

Governments have also periodically repeated a commitment to reduce red tape and introduce more proportionate, lighter touch approaches. However, some critics demand more radical action to get audit, inspection and scrutiny “off the backs” of professionals in front line services such as schools, hospitals and local authorities. In addition, constraints on public spending may lead to new incentives to reduce the level of inspection over the next few years. On the other hand, high profile failures such as MRSA outbreaks or child abuse cases demonstrate that even the current methods and levels of oversight may provide insufficient safeguards. So the debate continues.


II. The research

This briefing paper draws principally on research funded by the Nuffield Foundation in 2008–2010 entitled *The Use of Evidence in the Audit, Inspection and Scrutiny of UK Government*, undertaken by Professor Sandra Nutley, Dr Ruth Levitt and William Solesbury (University of Edinburgh) and Professor Steve Martin (Cardiff University). The research consisted of eight case studies of audit, inspection or scrutiny work undertaken in 2008–2009. **Table 2** gives brief details; further details are in the case studies and in Section V.

TABLE 2: THE CASE STUDIES

	England	Scotland	Wales
Service inspections	Care Quality Commission: HCAI (health care associated infection) inspection programme	HM Inspector of Education: implementation and impact of teachers' new terms and conditions	
Corporate local authority assessments	Audit Commission: trials of Comprehensive Area Assessment	Audit Scotland: Best Value Audit of a local council	
Value for Money audits	National Audit Office: Value for Money study of autism		Wales Audit Office: Value for Money study of fleet management
Scrutiny committee inquiries	London Borough of Harrow: relations with the local voluntary and community sector		National Assembly for Wales: inquiry into carbon reduction in energy production

In each case the researchers reviewed documents, attended public meetings, interviewed key players and observed private meetings of the audit, inspection and scrutiny teams. Emerging findings were discussed with each team, and a workshop was held with senior representatives of all eight bodies to explore the conclusions emerging from the project as a whole. The topics covered included how the teams made choices about what topics or service responsibilities to investigate, what evidence to collect, how to interpret and analyse it, how teams reached their conclusions, and how they chose to present them.



Given the diversity of the case studies, the nature of evidence gathered and how it was used varied considerably. However, we were able to make a number of general observations. These, and subsequent discussions with the audit, inspection and scrutiny bodies, form the basis for the *Principles and Practices* in this paper.

III. Principles and practices for effective use of evidence

From our case studies and the workshop with senior audit, inspection and scrutiny practitioners, we have identified eight *Principles and Practices* for the effective use of evidence in audit, inspection and scrutiny:

1. Be clear about **what is expected** of each audit, inspection and scrutiny project.
2. Consider the appropriateness and feasibility of different **methods** and ensure that you have the necessary **skills**.
3. Seek out a range of different **kinds of evidence**.
4. Test the **quality of evidence**.
5. Consider alternative **interpretations** of the evidence.
6. Tailor **reporting** to the needs of different audiences.
7. Check the **implementation** of findings and recommendations.
8. **Reflect** on the lessons for future projects.

In this paper, the discussion of each principle is followed by:

- the *main findings* that shaped it
- some *questions* that audit, inspection and scrutiny practitioners might wish to consider
- a *commentary* on the issues
- and a brief *case study* to illustrate the point.

Together we hope these will help in the planning of future audit, inspection and scrutiny work, and also inform those seeking to refine or reshape the accountability landscape.

Principle 1

Be clear about **what is expected** of each audit, inspection and scrutiny project

Main findings

All of our case studies had clear formal objectives, but often these were accompanied by less explicit informal expectations. Meeting those informal expectations often affected the way in which the audit, inspection or scrutiny was conducted, but this was sometimes hampered by lack of clarity or lack of shared agreement about what these expectations were. Projects varied in terms of the amount of time devoted to scoping and clarifying expectations beforehand.

Questions

1. Is the main purpose of the project to investigate past performance, examine present practices or put forward recommendations for the future?
2. What are the main aims of the exercise: what changes are sought?
3. Is the focus on outcomes and/or processes?
4. How broad is the focus: on a particular service or organisation, or on a wider policy and delivery system?
5. What constraints of time, resources and procedures will shape the project?
6. Are formal project objectives aligned with informal expectations?
Do the informal expectations need to be clarified?

Comments

1. Being clear about the expectations of stakeholders helps define the purpose of the project and keeps it on track. Formally agreed terms of reference are a useful starting point. The terms of reference may be determined to some degree by the official remit and powers of the audit, inspection or scrutiny body. But they should go beyond that and also be specific to the particular task. Being clear about both formal and informal expectations is essential if key stakeholders are to understand and “buy into” the specific terms of reference of an investigation.
2. The intentions of any audit, inspection or scrutiny may be to:

- a. ensure compliance
- b. identify good practice
- c. promote improvements
- d. identify solutions to a problem
- e. open up an issue for public debate.

In some projects one or more of these may be explicit objectives; others may be implicit. It is important to be aware of both.

3. Taking time over initial scoping work can be a useful way to explore these questions and to clarify the focus of the project. This work can be conducted by the project team or by an external consultant or by a combination of the two. Scoping work may also help to highlight conflicting expectations from different stakeholders that should be addressed before the work proceeds further.
4. Audit, inspection and scrutiny traditionally focused on past performance (most evidently in the case of an inquiry into a high profile failing). Increasingly though they are expected to assess current performance and/or future prospects and policies.
5. The terms of reference can help to limit and frame an investigation and ensure it is commensurate with the time and resources that are available, and the procedures that are required. Together, the terms of reference and the scoping exercise can help the project team create an achievable work plan, identify the tasks to be done and the evidence required, and assign team responsibilities and manage the project.
6. Some projects can proceed in a linear fashion, from the terms of reference to an evidence gathering phase, to analysis, to a stage in which conclusions are drawn. Other projects need to adapt and evolve in a more iterative way, as evidence comes in or as analysis suggests interim conclusions, which need to be tested by further evidence gathering. So the scope of a project may need to be revisited as the project progresses.
7. The standards of evidence required and the scale and scope of work to be done need to be proportionate to the question at hand. Assessing the risk factors associated with the body or service under investigation, and with the investigating body itself, help to establish what would be proportionate, for example:
 - a. If past performance or secondary data on current performance of the body being investigated suggest a risk of serious underperformance, especially in important areas.
 - b. If the audit, inspection or scrutiny body has insufficient data to make a reasonable risk assessment of performance (the greater the lack of data, the closer the investigation needs to be).
 - c. If there is a risk that the audit or inspection or scrutiny body will get it wrong (the greater this risk, the closer the investigation needs to be).

Case study

National Audit Office (England): Value for money study on supporting people with autism through adulthood

This study concerned the provision of services – including health and social care, education, benefits, and employment support – for adults with Autistic Spectrum Disorder (ASD) and their carers. An initial scoping exercise explored what is known about the topic, considered alternative foci for the study, and identified 38 issues to be addressed about current provision and performance.

These issues were coded by theme and lead department or agency. As an example, under the theme *Health and social care and agencies DH, NHS and LAs*, the lack of precise data on the prevalence of ASD as a basis for service planning was noted. Then for each issue there was a statement of the information required, its source, the methods to be used in gathering and analysing data, the risks attached to that and how they might be mitigated. This matrix was the basis for work planning throughout the project.

Principle 2

Consider the appropriateness and feasibility of different **methods** and ensure you have the necessary **skills**

Main findings

In most of the cases we studied, investigating teams had to balance their desire to gather substantial amounts of evidence with their need to minimise the burden of data collection on those being audited or investigated. Sometimes existing administrative data were available, but in most cases the emphasis was on gathering new primary evidence.

Methodologies varied but few projects used an approach that explicitly tested propositions, much less alternative explanations. The use of self assessments made by those being audited or inspected also varied. In some cases inspectors regarded these more as a way of gauging the self awareness of audited bodies rather than as reliable judgements in their own right. Data handling techniques ranged from sophisticated to rudimentary. And the sharing and pooling of data was often hindered by practical and cultural problems.

Questions

1. What kinds of evidence will the project need in order to fulfil its objectives?

2. What is already known about the topic/area under investigation? Can you use existing (secondary) evidence in some areas, rather than collecting new (primary) evidence?
3. Are both quantitative and/or qualitative analysis necessary? Why? How much of each?
4. What do these project plans imply about the skills the investigating team will need?
5. Is the work to proceed inductively (in an exploratory manner) or deductively (by testing some prior propositions)?
6. Will self assessments form part of the evidence? In what way?
7. What are the advantages and disadvantages of sharing raw or analysed data and evidence with others before your interpretation is complete?

Comments

Methods

1. Most projects include seven main tasks:
 - a. scoping
 - b. gathering evidence
 - c. analysis
 - d. discussing evidence
 - e. reaching findings and conclusions
 - f. making judgments
 - g. reporting.
2. For these tasks evidence may be needed about:
 - a. the policy or practice being investigated (know what)
 - b. the objectives it serves (know why)
 - c. how it has been delivered (know how)
 - d. the stakeholders (know who).
3. Some projects start with clearly defined propositions from the outset (for instance, whether an NHS trust's policies and practices comply with specific duties laid down in the Hygiene Code). Project managers then design investigations to test the propositions (a deductive approach). The propositions may derive from one or more of the following five factors:
 - a. the legal duties with which the body under investigation should comply
 - b. the professional experience of the investigators

- c. advice from external experts/consultants
 - d. hypotheses generated at the start of the investigation by the audit, inspection or scrutiny team (possibly in a scoping exercise)
 - e. widely held preconceptions or assumptions about the issue(s) under investigation (which may or may not be true).
4. Other projects begin with fewer prior assumptions or conditions and adopt a more wide-ranging approach. In these cases, teams start by identifying the broad topic or area to be investigated (for example, the local authority's relationships with the voluntary and community sector), and gather and sift evidence iteratively in order to see what trends and patterns emerge (an *inductive* approach).
 5. Projects may sometimes benefit from using both approaches, for example by conducting a broad, inductive first phase to identify specific propositions, followed by a focused deductive second phase to test those propositions formally. An early choice about whether deductive and/or inductive approaches are appropriate should always influence the choice of methods and decisions about what evidence is essential.
 6. Self assessment is becoming an increasingly important factor in improving public services. Organisations seeking to improve their performance tend to undertake various self assessments regularly. When these are compared with external assessments, they can show whether the organisation under review is able to be critical of its own performance, and hence what it may need to learn in order to improve. Formal self assessments may exist independently of the project, or may be required as part of the project. Informal self assessment may be achieved through structured interviews by the audit, inspection or scrutiny team.

Skills

7. Aside from the methods chosen, the project tasks listed above require a number of distinct skills, including:
 - a. investigative skills (e.g. reviewing documents, conducting interviews, observing practice)
 - b. analytical skills (handling and interrogating quantitative and qualitative data);
 - c. facilitation skills (chairing hearings, discussions or focus groups)
 - d. negotiating skills (building agreement on findings, conclusions or judgements)
 - e. consultancy skills (developing advice on improving performance)
 - f. communication skills (getting results across to diverse audiences).

8. Project teams need to tailor the particular mix of tasks and skills, and the relative weights to give each of them, to serve the purpose of the project, given the resources available.
9. Quantitative and qualitative methods of analysis each require specialist skills, and each carries their own particular strengths and weaknesses. Teams need to make well-informed choices about which qualitative and quantitative data and analyses to use, and when to use them.
10. Methods of handling and storing data need to be secure, robust and well-managed; designing these so that confidentiality can be maintained while data are used requires care. This may pose particular challenges if data are contributed by or shared between different organisations.
11. Investigations need to build in time and resources for testing and piloting of proposed new methods, in order to identify potential weaknesses or biases which could undermine the reliability of the evidence or its interpretation.

Case study

Audit Scotland: Best Value Audit of a local council

Best Value Audits hold local authorities to account for the duties they have under the Local Government in Scotland Act 2003. Each audit of an individual authority focuses on past performance and present capacities; with the aim of encouraging service improvement. In the audit of South Lanarkshire Council the team's approach was broadly deductive, based on adherence to the principles of Best Value, but a more inductive approach was used in the scoping phase of the project to arrive at the working propositions to be investigated during the audit.

The audit used multiple methods, gathering evidence from documentary, oral and visual sources in both quantitative and qualitative forms. They included interviews, focus groups, observations, document analysis, surveys, the council's self-assessment, and performance indicators. These diverse methods enabled the auditors to deepen their understanding of how the council worked – “fitting together pieces of a jigsaw” was one auditor's description – and to have confidence in their judgments. In doing so the team drew on the skills of financial audit, performance audit and project management and, for some team members, previous experience working in local government.

Principle 3

Seek out a range of different kinds of evidence

Main findings

Most of the audit, inspection and scrutiny work we observed involved fairly conventional forms of evidence and evidence gathering. In some cases however, teams experimented with new forms of evidence-gathering. The resources available to teams and the traditional ways that the particular audit, inspection or scrutiny bodies worked heavily influenced the sources that tended to be used. For example, the inspectorate tradition is to hear and see evidence with their own ears and eyes. Consideration of using other sources of evidence, through learning from what other audit, inspection or scrutiny bodies do, could help widen the range of evidence considered.

Questions

1. Is the team aware of the full range of evidence sources they might use? Do members of the team periodically stop and consider whether new evidence is available?
2. What are the costs and benefits of using existing (secondary) and collecting new (primary) evidence?
3. Is documentary and/or oral and/or visual evidence needed?
4. Are both qualitative and quantitative data desirable?
5. Will the project rely solely on explicit (formal) knowledge or is it also seeking to access tacit (informal) knowledge, including experiences and opinions?
6. Who will evidence be gathered from

Comments

1. The main sources of evidence for audit, inspection and scrutiny projects are listed in **Table 3**, differentiating secondary (existing) and primary (newly gathered) sources. These sources of evidence have different strengths and weaknesses.

TABLE 3: MAIN SOURCES OF EVIDENCE

SECONDARY SOURCES	
Secondary data	Data already available, previously collected by the organisation or by others.
Literature review	Looking at past research or commentary to assess what is already known.
Comparative studies	Looking at how similar activities are undertaken in other settings.
Scenarios	Formal speculation about future trends or events.
Document review	Reports or correspondence, either internal to the organisation or produced outside.
Self assessment	The organisation's own monitoring and evaluation of its performance.
PRIMARY SOURCES	
Consultation	Seeking views of the staff, service users or other stakeholders of the organisation under review.
Survey	Systematically gathering data from staff, service users or other stakeholders.
Focus group/ discussion	Usually with staff or service users.
Hearing	Where invited witnesses make oral presentations and are questioned, usually in public.
Interview	With main informants, usually undertaken one to one, either face to face or by phone.
Observation	Usually on visits to sites where services are provided; likely to be non participant observation.

2. The costs (time, money, opportunity) of gathering evidence vary between sources. Because audit, inspection and scrutiny bodies are required to minimise the burden they place upon the organisations they investigate, they may start by considering existing evidence where possible (such as reports, self-assessments, secondary data, or previous audits or inspections), as this is likely to reduce costs and burdens. However, such evidence may be less directly relevant, less focused on the question at hand, or less up to date. So an essential early task is to identify the gaps that new, primary data collection (such as from consultations, interviews, or surveys) needs to fill.
3. Three broad categories of evidence are: documentary, oral, and visual evidence, which can offer distinct yet complementary insights. Projects can make use of all three. Oral evidence (gathered through interviews, focus groups and discussions, or hearings) can help to bring a subject alive; as can visual data gathered on site visits. Such live, personal encounters can be very influential in the investigation, and may be given disproportionate weight. To balance this, oral and visual evidence can be recorded and documented so that it can be considered dispassionately alongside other documentary evidence.
4. Quantitative and qualitative data have different strengths. Quantitative data (for example, from secondary sources or surveys) can be analysed to reveal

patterns, correlations and trends that provide measures of the performance of the organisations and offer comparisons with standards, targets or benchmarks. Qualitative data (for example, from observation, hearings or interviews) can provide information on behaviours, attitudes and opinions that can enhance understanding of the reasons for variations in performance.

5. Some types of knowledge are easily communicated (for example formal written guidelines). Other knowledge is tacit (held in people's heads) and this is often less easy to access. Investigations often need to engage with tacit knowledge in order to dig beneath the surface of the "factual", that is, empirically verifiable, evidence. This means being able to:
 - a. tap experience and/or opinions
 - b. decide the appropriate weight to attach to this evidence
 - c. decide how best to present it.
6. Sometimes it may be worth casting the net for evidence from different stakeholders as widely as possible so that as many voices as possible have been heard. Divergent perspectives can help the interpretation of evidence. This may also be useful to alert a wider group of people that an audit or inspection is taking place.

Case study

National Assembly for Wales Sustainability Committee: Inquiry into carbon reduction from energy production

The committee is responsible for scrutinising Welsh Assembly Government policy regarding sustainability issues. This inquiry was one of a series on policies for meeting carbon reduction targets. It was conducted by the Assembly Members who form the Committee. There were three main sources of evidence:

- written briefings prepared by in-house researchers providing background information and summarising existing evidence;
- written evidence from outside organisations and individuals submitted in response to an open consultation; and
- oral evidence given at formal Committee hearings by Ministers and officials, invited experts and stakeholder representatives.

Members of the committee also drew upon personal experience and the concerns of their constituents. In this particular inquiry the committee did not make any site visits, hold any focus groups or commission any surveys, though its work often involves these forms of evidence gathering.

Principle 4

Test the quality of evidence

Main findings

In most case studies, teams worked hard to ensure that evidence was robust and could withstand challenge; this involved testing it in various ways. Teams often used a technique of triangulating across different sources of evidence, to see if the different sources gave the same picture. But the ways in which it was understood and put into operation varied. Other methods of validation were rare.

Questions

1. What criteria give confidence that the evidence is strong enough to support the findings, conclusions and judgments in audit, inspection and scrutiny work?
2. What procedures assure the overall quality of the project, or are likely to yield strong evidence?
3. Are the bodies under investigation given an opportunity to comment on provisional findings and conclusions? Should they be? Are their comments given particular weight?
4. How transparent is the evidence informing the project's conclusions?
5. Is it possible to identify evidence of good practices reliably without using experimental methods?
6. Are there any second opinions on which the conclusions and judgements rely?

Comments

1. Triangulation is one way to cross-check the quality of evidence and its suitability for use in interpretation. Cross-checks may compare the findings from several data sources, or from different methods of gathering and analysing data, or may use evidence presented by different inspectors/auditors, in order to interrogate the data and see if they are saying the same thing. If there are discrepancies, it may be worth re-examining data to seek possible reasons.
2. It may be useful to seek second opinions about the evidence or data from experts or peers who have not been part of the project team, or who are external to the audit, inspection or scrutiny body. Such experts may, for example, challenge the audit or inspection team's (possibly unspoken) assumptions,

may see patterns or discrepancies that the team has missed, or may simply articulate interpretations that the team has not considered.

- 3. Four criteria can be used to assess the quality of evidence: relevance, robustness, sufficiency and legitimacy.

TABLE 4: QUALITY CRITERIA FOR EVIDENCE	
Relevance	<ul style="list-style-type: none">• salient to aspects of the topic (know what, know why, know how, and know who)• up to date• specific or local
Robustness	<ul style="list-style-type: none">• factually accurate (error-free)• consistently assessed (reliable)• representative (controlled for bias)• traceable (replicable)
Sufficiency	<p>What counts as enough evidence will often be a trade-off between:</p> <ul style="list-style-type: none">• the strength (and defensibility) of the findings• conclusions and judgements resting on the evidence• the constraints of time, cost and burden that apply to the project
Legitimacy	<p>Including stakeholders in evidence gathering, analysis and discussion, may shape how they view the quality of the evidence.</p>

- 4. Some audit, inspection and scrutiny bodies have formal processes that require them to obtain comments on provisional findings or conclusions from the organisation being investigated. This can be a valuable element of quality control, which helps to identify possible factual inaccuracies or misinterpretations before the investigation is completed and the report is finally issued. Audiences are often more receptive to (critical) findings when they are given advance warning of the main points in the report before it is published. Adopting a policy of “no last minute surprises” can be particularly helpful in this context. If the investigating team communicates and debates emerging and interim findings, that gives the service provider time to begin to absorb the messages and think ahead constructively about potential responses. This moderation or clearance must be used carefully, however, so that the independence of the accountability function and of the project are not compromised. This needs particularly careful handling in situations of heightened political interest.
- 5. Transparency regarding the methods, evidence and findings of a project can enhance its status, particularly among the organisations and individuals being assessed, and other key stakeholders. In principle, transparency builds trust by being inclusive and enabling access to information and judgements, to see if they think the interpretations are fair. In addition, transparency of methods allows others to see that the methodology used is thoughtful, fair and comprehensive,

and so it affects judgements on the legitimacy of the assessment exercise. In practice, transparency is difficult to achieve particularly in relation to judgements because judgements are rarely based on explicit algorithms. Transparency can also be difficult where the methods are algorithmic (such as scoring rules), but the rules are complicated.

Case study

HM Inspector of Education (Scotland): Inspection of the impact of the implementation of the Teachers' Agreement

The inspection used a mix of secondary evidence from previous inspections and research and primary evidence from interviews and focus groups with Local Education Authority staff and from school visits in 16 local council areas. This evidence was tested for its relevance and reliability. Relevance was pursued by organising data on each of the study's three themes (CPD, collegiality and chartered teacher status) under three headings (good practice, impact and future developments). The reliability of evidence was established through comparing data from different sources and, in particular, by ensuring that inspectors saw things for themselves on school visits and classroom observations, to avoid "having the wool pulled over our eyes". Consideration of the sufficiency of evidence was achieved through team review processes and wider review of draft reports by other inspectors and senior managers. The emerging findings were discussed with key stakeholders in order to identify the legitimacy of the evidence and some overall conclusions.

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Principle 5

Consider alternative **interpretations** of the evidence

Main findings

The relationship between evidence and findings in the case study projects was not simple or straightforward. Evidence and judgement often evolved in parallel and the interplay between them was shaped by team members' tacit knowledge and intuition.

Increasingly, audit, inspection and scrutiny organisations are being asked to investigate and comment on service outcomes and impacts. Most of the projects experienced significant problems in judging outcomes. The lack of counterfactual data and the likelihood of time lags made simple cause and effect relationships unlikely and attribution difficult. There were also larger questions about "whose outcomes" should be taken into account.

Questions

1. What methods of interpretation can be used?
2. What influences on the interpretation of evidence are valid and invalid?
3. How far should politics enter into the process?
4. What to do when evidence is inconclusive?

Comments

1. Evidence by itself does not lead directly to findings and conclusions, let alone to good judgements and sound conclusions. Evidence always needs to be interpreted in order to inform findings, judgements and conclusions. This may become a dynamic process in which there is an interplay between evidence, interpretations and judgements.
2. Forming a judgement is a matter of weighing up evidence in support of alternative interpretations. Customary practice in the particular audit, inspection or scrutiny body may provide one formal process for arriving at judgements. But it is often useful to test alternative interpretations and conclusions to see where the weight of evidence points, and which overall conclusions, however nuanced, are best supported by the evidence. Using explicit alternatives may provide reassurance that you have worked through the range of supportive evidence and that you know why, in the end, you reached the conclusions that you did.
3. It is important that team members have face to face or telephone discussions of the main conclusions and interpretations at each main stage of the audit or inspection. This ensures that team members are robustly contributing to and reviewing their collective understanding of the evidence and its use, and is likely to ensure that alternative explanations are pitted against each other in discussion.
4. Different team members are likely to bring diverse influences to the process of interpretation, including tacit knowledge, expertise, past experience, and intuition. It may be appropriate to have specialist analysts working alongside the main team of inspectors and auditors, particularly when it comes to analysing quantitative data and/or qualitative data. This may also be the point at which political judgements and wider considerations may be brought into the discussion.
5. In seeking to arrive at truths about the service and organisations under investigation, it may be helpful to use criteria such as correspondence

(are the interpretations consistent with the empirical evidence?), coherence (do the interpretations make overall sense even if they do not fit all the available facts?), and consensus (have the interpretations been negotiated with the body being assessed?).

6. Sometimes it is impossible to reach a definitive conclusion on the basis of the available evidence. In these cases it is important to be clear about how judgements have been made, on what evidence they rely, and what evidence is contradictory or missing or difficult to use. It is also important to be explicit about the status of the judgement, the degree of confidence that can reasonably be placed in it, and the implications of any caveats and aspects that require further investigation. In some cases the conclusion may simply be that firm conclusions cannot be drawn. But in these cases it is at least helpful to ensure that the reasons why a firm conclusion cannot be drawn are laid out, and pointers to what would be needed to draw a conclusion are discussed.

Case study

Care Quality Commission (England): Health care associated infection inspection programme

The inspection focused on the risk of infection in NHS acute hospitals. It collected evidence on compliance with the three elements of the pre-existing Hygiene Code: management, clinical care protocols, and healthcare workers.

The Hygiene Code contains several judgement words, like “appropriate”, “suitable”, “sufficient”. In interpreting evidence to reach such judgements the teams used the evidence to reason, and then debated their findings. Implicit in their approach was a recognition that there were multiple players and multiple realities rather than a single truth. The team’s conclusions were reviewed by an advisory panel tasked to secure consistency of judgements across different sites and teams.

Principle 6

Tailor **reporting** to the needs of different audiences

Main findings

Final reports were intended for several audiences, usually the commissioning body (audit offices, inspectorates, scrutiny committees) and the service providers (local authorities, NHS trusts etc.) in the first instance. But local service users and citizens

as well as national parliaments, government departments and agencies were also significant audiences.

Reports varied in format, length and distribution, and not all were intended for wide public circulation. In most cases findings were only reported in one format (the full report) but in a few cases these reports were supplemented with press releases, DVDs and web-based summaries, including good practice examples.

Consideration was sometimes given to showing more detailed evidence or analysis to a smaller group of people – the body being investigated or others – so that they understand the reasons for the conclusions.

Questions

1. Who are reports intended for?
2. How can complex evidence be summarised accurately and accessibly?
3. What access is provided to the evidence underpinning the reported analysis and judgements?
4. Can third parties be used to disseminate findings (for example press and other media)?
5. Would different audiences benefit from receiving different (tailored) reports?
6. What mechanisms are best for reporting (e.g. written reports, oral briefings, web based materials)?

Comments

1. Usually the two initial audiences for most audit, inspection and scrutiny investigation reports are (a) their commissioning body and (b) the organisations providing the service being investigated. Other audiences are usually important too and may be the ones whose very interests the audit, inspection or scrutiny is supposed to serve. This may include service users, as well as wider publics including voters and taxpayers. Parliament or government departments have an interest and responsibility too, insofar as they sponsor or fund the body undertaking the audit, inspection or scrutiny.
2. Evidence used will vary in nature, format and scope. It will be drawn from various sources and gathered and dissected in various ways. Reports need to bring these strands together so that the questions posed are logically stated, addressed and answered, and this may not follow the same ordering as the actual inquiry. Reports should construct a consistent line of reasoning

throughout, which informs readers and carries them through to convincing conclusions. While the narrative needs to be based on the evidence, it has its own independent role.

3. It may be helpful to distinguish specialist and non-specialist audiences, and consider separately the different types of information they may need, or that they will show more interest in. Intermediaries such as print or broadcast journalists can play an important part in getting the messages across to generalists.
4. Investigating teams should consider the objective of the reporting in each case, and the contribution of content, style and format of reporting to achieving that objective. For example, how effectively does a written report convey information and interpretation? How effective are “star ratings” or other scoring systems? Care is needed in summarising complex evidence, as there is sometimes a trade-off between conveying a complex picture accurately and being accessible.
5. Different presentations of a single project may be needed for different audiences. This may be because different audiences need information relevant to their particular interests, or it may be needed so that the report is readily understood by different audiences. One particular question is about the presentation of the evidence: is it presented in a way that is appropriate to the audience? This may mean full tables in a long report and a summarising graph or chart in the report aimed at a wider audience. Narrative style, length of the report and format are other variables that need to be considered. In some cases, it may be useful to test the needs and preference of the audiences, experimenting with different types of reports until you are satisfied there is a workable template. It may also be useful to employ professional writers and designers for reports intended for non-specialist audiences.
6. A written report is the common and familiar medium for audit, inspection and scrutiny investigations, now usually made available as a downloadable file from the body’s website. It is readily accessible to most (but not all) people and places the report on the record. Other media – such as short printed summaries, live presentations, workshops, DVDs, podcasts, and web based databases and other tools – may also be useful and appropriate.
7. It is important to consider the quantity of information that is published. Should audit, inspection and scrutiny investigations publish all the supporting evidence that forms the basis for judgements (such as information about local risks)? Such information may potentially be useful, but it may also be misunderstood and lead to unfair conclusions. This is even more difficult when the data are not in the public domain.

Case study

Audit Commission (England): Comprehensive Area Assessment summer trials

The study piloted the methodology for a new form of assessment of how effectively local public services are improving quality of life and value for money in local communities. It was undertaken jointly by the Audit Commission, the Care Quality Commission, HM Inspectorates of Constabulary, Police and Probation, and Ofsted. The trials reported on the performance of the Local Area Agreement and Local Strategic Partnerships in 10 pilot localities. Market research for the reports including stratified profiling of the public e.g. community activist, public service staff. Web based reporting was also investigated. Based on the experience of the trials, reporting of Comprehensive Area Assessments in 2009 comprised:

- A printed report with a concise summary and more detailed coverage that provides links to evidence – the format of reports will not be standardised, but negotiated locally.
- A new Oneplace website (launched December 2009) on which all reports can be interrogated, a “national overview report” is provided and advice made available on “making a difference in your area” (www.oneplace.direct.gov.uk).

In support of these reporting arrangements all team leaders were given media training.

Principle 7

Check the **implementation** of findings and recommendations

Main findings

Mechanisms for checking on the implementation of recommendations and for evaluating the impact of projects varied. In some cases, follow-up activity was built into the process, but on the whole, follow-up activities after publication of the report were not well developed. In some cases, it was not explicit whether or not there would be a follow-up, who should do it, or how extensive it should be.

Questions

1. Other than reporting, are there any further actions that should be taken to secure action? Or is this someone else's responsibility entirely?

2. Has the report made recommendations for specific actions? Does it require or recommend clear milestones? Is it made clear who has responsibility for implementing recommendations?
3. More generally, is it necessary to have a formal process of follow-up to ensure recommendations have been implemented? Should this be a regular part of the work-plan? And whose responsibility?
4. Can informal processes be used to follow-up? Is this instead of or in addition to (or prior to) formal processes?

Comments

1. Sometimes the reporting of a project is treated as if it were the end of the matter, but it is actually the beginning of a new responsibility. It is therefore important to consider how the conclusions from a project will feed into policy and/or practice, and who has responsibility to monitor what happens next.
2. Implementation and change are far more likely if recommendations are clear and specific, and if responsibility and timescales for acting on them are given to named individuals and/or organisations. Of course this is more likely in some circumstances than in others, but it should be considered where it is appropriate (which may not be in a published version of a report).
3. Recommendations from audit, inspection and scrutiny are frequently made without reference to the reviewed organisation's overall priorities. The implementation of recommendations will have opportunity costs. If the recommendations affect statutory, core responsibilities such as minimum standards of quality or safety, recommendations will have to be accommodated in some way. Even so, implementation of the project recommendations may be delayed or partial. Where there are not statutory requirements to fulfil, the pressures for implementation may be less.
4. Some audits, inspections or scrutinies require a formal response from the body investigated, sometimes with an action plan to secure improvement. There may also be formal procedures for periodic progress chasing. Where these do not exist, there may be a case for re-visiting issues on a regular basis to check progress. The audit, inspection or scrutiny body may or may not have any responsibility for this; if it is agreed that it does, a plan for follow-up should be put in place before the project ends.
5. A number of informal processes can also create pressures for follow-up. Reports may be debated in legislatures where the executive must defend its position. Media coverage may also require a response. And where projects have

intentionally engaged a wide range of stakeholders, there may have grown a “coalition of support” for action.

Case study

London Borough of Harrow: Review of delivering a strengthened voluntary and community sector

The Review was commissioned by the Oversight and Scrutiny Committee from a group of councillors and co-opted representatives of local voluntary and community organisations. It also had two sponsors – the Borough’s Director of Finance and the Chair of the Harrow Association of Voluntary Service – whose role was to symbolise the joint ownership of the review, to keep it focused on important issues and to advise on who would be needed to carry its conclusions forward. Also in the course of the Review, four half day consultation meetings were held with members of local voluntary and community organisations. This open and inclusive approach had an impact on the implementation of the Review’s conclusions.

The final report contained 22 recommendations for both specific actions (e.g. to advertise the local Volunteer Centre on the Borough’s website) and broader aims (e.g. to seek people with a passion for developing social entrepreneurship and social capital). The report was submitted to the borough’s Cabinet (which committed itself to respond within 3 months) and to the Harrow Local Strategic Partnership. The Cabinet accepted just over half the recommendations for immediate implementation, and agreed to consider several others alongside the development of a Third Sector Strategy; it only rejected one minor recommendation. The Oversight and Scrutiny Committee committed itself to quarterly progress reports on the implementation of the Review’s recommendations.

Principle 8

Reflect on the lessons for future projects

Main findings

In some case studies, we found there were agreed or built-in processes to encourage reflection and learning during the project and again after its completion. But in the main these tended to be informal and were reliant on the enthusiasm of the project leader. We found only a few examples of formal reviews, sometimes involving external consultants, particularly where projects were part of a broader programme of audit and inspection activity.

Despite their different histories and cultures, there is much in common in the practices of audit, inspection and scrutiny and mutual learning across these different fields would be worthwhile.

Questions

1. How can the value of audit, inspection and scrutiny be measured?
2. How are audit, inspection and scrutiny bodies themselves held accountable for their effectiveness?
3. How can the body learn from its own experience and that of others, within and between audit, inspection and scrutiny communities?

Comments

1. At the end of each project an audit, inspection or scrutiny body should reflect on what has worked well and what could have been done better. It is also important to capture and record these reflections in a format that future projects can access and learn from. These may be reflections about the particular project or general reflections about the process.
2. Particularly at times when public spending is under severe pressure, it is important that audit, inspection and scrutiny bodies are able to demonstrate the value of their work. This means having evidence about the costs and benefits of their work and ensuring it is proportionate.
3. In some cases independent expert evaluation of the impacts of a project (or series of projects) will be valuable. In others it may be important to obtain feedback from those who have been subject to audit, inspection and scrutiny.
4. There is also scope for much more learning and sharing of insights and experience between audit, inspection and scrutiny bodies, both across sectors and between countries.

Case study

Wales Audit Office: Value for money study on vehicle fleet management

The study of fleet management was the first of four investigations into asset management by public sector bodies undertaken by the Wales Audit Office. The aim of the enquiry was to help local authorities, health trusts, police forces, fire and rescue services, ambulance trusts and national park authorities to find ways of improving the use of their vehicles

in order to reduce costs and carbon emissions. Evidence from 50 local sites was used to identify good practice which was disseminated through “shared learning seminars”, a national conference and a web-based “Good Practice Exchange” featuring exemplars and self-assessment tools (www.wao.gov.uk/fleetmanagement). This was a new approach for the Wales Audit Office. It has assessed its impact through feedback provided by public bodies, the level of savings achieved, the number of hits and downloads from the website, the level of press coverage, and external validation from the Chartered Institution of Public Finance and Accountancy.

IV. The continuing debate

The future of audit, inspection and scrutiny is inextricably linked to wider political debates about the role of the state, the growth of government agencies, the performance of public services and the need for de- or re-regulation. In the run up to the 2010 General Election these issues have particular relevance and are the subject of intense lobbying and debate. Cutbacks in public spending are likely to have consequences for the style and scale of future audit, inspection and scrutiny activity, and there are some sharp differences of approach between the main political parties, with the Conservatives, for example, committed to abolishing the recently introduced Comprehensive Area Assessment in favour of greater self-regulation by local public service providers. There are general concerns about the number of overlapping audit, inspection and scrutiny bodies, and the landscape may well change over the next few years.

But some degree of audit, inspection and scrutiny will undoubtedly continue, as it has become part of wider democratic governance, especially where matters are technically or bureaucratically complex. What is likely to become more important, partly as result of financial circumstances, and partly as a result of reflection about the past few years of scrutiny practice, is more thoughtful, sharper use of evidence to provide precise answers that have the potential to be translated into changes in practice. Historically, political imperatives have often influenced uses of evidence in all forms of governance. Future policy decisions and professional practices should be informed by a better understanding of how audit, inspection and scrutiny can use evidence more effectively to form judgements and promote improvements in the quality of public services.

V. The case studies

Further information about the research is available from www.ruru.ac.uk.

Care Quality Commission (England): Health care associated infection (HCAI) inspection programme

The Care Quality Commission (CQC) was created in April 2009 from the merger of the Healthcare Commission and the Commission for Social Care Improvement. It inherited their inspection roles but these were augmented by regulatory powers whereby NHS Trusts and social care providers are obliged to register with the CQC and the CQC can legally enforce its judgements.

The Hygiene Code (formally the Code of Practice for the Prevention and Control of Health Care Associated Infections) has existed since 2006. In its 2009 version it specified 11 duties under three headings – Management, organisation and the environment; Clinical care protocols; and Healthcare workers. The CQC inspects all NHS Trust hospitals annually for compliance with the code. The inspection programme in our case study ran from April 2008 for 12 months.

www.cqc.org.uk

HM Inspector of Education (Scotland): Inspection of the impact of the implementation of the Teachers' Agreement

Scotland has had its own schools inspectorate since 1840. HM Inspector of Education (HMIE) became an executive agency in 2001 to strengthen its independence and impartiality. It evaluates the quality of pre-school education, school education, teacher training and continuing professional development, community learning and development, further education and local education authorities.

In 2007, HMIE reported on the impact of a 2001 agreement on teachers' pay, grading, conditions and continuing professional development (known as TP21). The review was initially requested by the Scottish Executive (later Government). The Scottish Parliament Education Committee then requested continued monitoring. Our case study focused on an investigation of the impact of three specific aspects of TP21: enhanced opportunities for continuing professional development, provision of collegiate time for teachers; and the new Chartered Teacher status (which recognises and rewards experienced teachers who stay in the classroom). The investigation of these three aspects ran from June 2008 to November 2009.

www.hmie.gov.uk

Audit Commission (England): Comprehensive Area Assessment (CAA) summer trials

The Audit Commission was established initially in 1982 to audit local authorities in England and Wales, had its powers extended to health services in 1990 and its remit consolidated in the Audit Commission Act 1998. (Post-devolution Wales acquired its own Wales Audit Office in 2004.) One of the Audit Commission's primary objectives is to improve the economy, efficiency and effectiveness of local government, through both an audit and inspection process and value for money studies.

From 2009 the Audit Commission is leading a new, joint Comprehensive Area Assessment (CAA) of the achievement of local strategic partnerships (LSPs). CAA involves seven inspectorates working jointly to gather and analyse evidence and reach agreement on their assessment of the LSP: Audit Commission, Commission for Social Care Inspection and Healthcare Commission [now Care Quality Commission], HM Inspectorate of Constabulary, HM Inspectorate of Prisons, HM Inspectorate of Probation, and Ofsted. Our case study was the 2008 pilot of the proposed CAA methodology, known as the "summer trials", from July to October 2008, followed by analysis and amendments to method, in time for the launch of CAA nationwide in April 2009.

www.audit-commission.gov.uk

Audit Scotland: Best Value Audit (BVA) of a local council

Audit Scotland carries out financial and performance audits of around 200 public bodies. Best Value Audits of Scottish local authorities (formally known as Best Value and Community Planning Audits) were introduced in 2003 to assess the extent to which local authorities are meeting new statutory duties to secure Best Value (defined as achieving continuous improvement in performance) and Community Planning (ensuring local organisations work together and engage local communities). The main focus of BVA is on a council's corporate governance and capacity.

Audit Scotland undertakes BVAs of all Scottish local authorities on a three year cycle. Our case study was the audit of South Lanarkshire Council undertaken between March 2008 and January 2009.

www.audit-scotland.gov.uk

National Audit Office (England): Value for money study of supporting people with autism through adulthood

The National Audit Office (NAO) acts, on behalf of Parliament, as the external auditors of English central government. It has two main activities: audits of the financial statements of government departments and agencies and topic-based value for money (VFM) studies. The latter examine the economy, efficiency and effectiveness with which resources have been used in discharging functions. The focus is thus on the delivery of policy. The NAO has discretion to choose what it studies. It undertakes around 60 such VFM studies each year.

Our case study examined the provision of services – including health and social care, education, benefits and employment support – for adults with Autistic Spectrum Disorder (ASD) and their carers in England. It ran from January 2008 to December 2009.

www.nao.org.uk

Wales Audit Office: Value for money study on vehicle fleet management

The Wales Audit Office (WAO) was established post-devolution in 2004 to take over the functions hitherto exercised in Wales by the National Audit Office and the Audit Commission. Its remit covers audit of central government, the health service and local government. It also produces VFM studies on particular topics. The Auditor General determines the content of its work programme and the topics to be covered by VFM studies in consultation with the National Assembly for Wales' audit committee and local public bodies.

The "Making the Connections" strategy seeks to improve the efficiency of public services in Wales and in 2008 the WAO initiated a four year study of good practice in asset management by public sector bodies. This is in four phases focused on: vehicle fleets, buildings, plant and machinery, and IT. Our case study focused on the study of fleet management which was conducted between January and July 2008.

www.wao.gov.uk

London Borough of Harrow Scrutiny Committee (England): Review of delivering a strengthened voluntary and community sector

An optional scrutiny function was introduced for English local authorities in the Local Government Act 2000. The London Borough of Harrow embraced the concept of backbencher scrutiny in association with a Leader and Cabinet model for the executive. Following a change of political control in 2006, from Labour minority to Tory majority, new scrutiny structures and processes were introduced that replaced

the former service-specific scrutiny committees with a single Overview and Scrutiny Committee, meeting monthly, to supervise a programme of individual scrutinies which it would commission and appoint ad hoc groups to undertake.

Our case study scrutiny focused on the local authority's relations with the local community and voluntary sector, including issues of collaboration, funding, and the use of community assets and premises. It ran from March to December 2008.

www.harrow.gov.uk

National Assembly for Wales Sustainability Committee: Inquiry into carbon reduction from energy production

The Sustainability Committee was created in 2007 following a major re-organisation of the National Assembly for Wales' committee structures. Committees are responsible for scrutinising Welsh Assembly Government policy and proposals for Assembly Legislative Competency Orders and Measures (which draw powers from Westminster). The Sustainability Committee is one of a small number of committees which has a remit that cuts across traditional ministerial portfolios.

In 2007 it initiated a series of inquiries into the Welsh Assembly Government's policies for meeting carbon reduction targets. The inquiry into energy production was the fourth of these. Previous inquiries considered residential carbon reduction, carbon reduction by transport and carbon reduction by industry and public bodies. The inquiry started in May 2008. It took evidence between June and November and its report was published in May 2009. The Assembly Government's formal response was published in June and a plenary debate was held in mid July.

www.wales.gov.uk

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